SBAR*

URINARY TRACT INFECTION

Before Calling MD/NP/PA:

☐ **Evaluate the resident** and complete the SBAR form (use "N/A" for not applicable)
☐ **Check VS:** BP, pulse, respiratory rate, temperature, pulse ox, and/or finger stick glucose if indicated
☐ **Review chart:** History of UTI, diabetes, indwelling urinary catheter
☐ Have relevant information **available when reporting** (i.e. resident chart, vital signs, advanced directives such as DNR and other care limiting orders, allergies, medication list)

S

SITUATION

The symptom/signs of possible UTI I am calling about are:

☐ Fever (increase of > 2° F; rectal temp > 100°F)
☐ New or increased burning, pain or urination, frequency or urgency
☐ New flank or suprapubic pain/tenderness
☐ Change in character of urine (new bloody urine, foul smell or amount of sediment) or lab report of + result (nitrite +, pyuria, microhematuria)
☐ Worsening of mental or functional status (confusion, lethargy, unexplained falls, recent onset of Incontinence, decreased activity or appetite)

If resident has indwelling urinary catheter:

☐ Fever or chills
☐ New flank pain or suprapubic tenderness
☐ Change in character of urine
☐ Worsening of mental status or function

B

BACKGROUND

☐ Primary diagnosis and/or reason resident is at the nursing home: _____
_____
☐ Vital Signs: BP_____/_____ HR_____ RR_____ Temp_____
☐ Pulse Oximetry_____ % on RA_____ on 02 at___L/min via _____(NC, mask)
☐ Mental status changes (e.g. confusion/agitation/lethargy)_____
☐ GI/GU changes (circle) (e.g. nausea/vomiting/diarrhea/impaction/distension/decreased urinary output/other)_____
☐ Change in intake/hydration_____
☐ WBC:_____
☐ Advance directives (circle) (Full code, DNR, DNI, DNH, other, not documented)
☐ Allergies:_____Any Other Data:_____

A

ASSESSMENT (RN) OR APPEARANCE (LPN)

FOR RN

☐ Resident has UTI (3-5 background symptoms)
☐ Resident has possible UTI (1-2 symptoms)

For Indwelling Catheter

☐ Resident has UTI (2-4 symptoms)
☐ Resident has possible UTI (1 symptom)

FOR LPN

☐ Resident appears to have new symptoms of concern

R

REQUEST

I suggest or request:

☐ Urine C&S
☐ Provider visit
☐ Antibiotic
☐ Other:
☐ Monitor symptoms
☐ Transfer to hospital
☐ IV or SC fluids

Staff name:_____RN/LPN
Reported to:_____(MD/NP/PA) Date_____ Time_____am/pm
If to MD/NP/PA, communicated by: ☐ Phone ☐ In Person
Resident Name:_____

(Complete a progress note on the back of this form)

* Adapted from INTERACT[II]

PROGRESS NOTE

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

☐ Family or health care proxy notified

Return call/new orders from MD/NP/PA Date____/____/____ Time_____/_____ am/pm

_____

_____

Signature_____RN/LPN Date:____/____/____ Time____/____ am/pm

Resident Name_____

* Adapted from INTERACT[II]